STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	A. BUILDING B. WING	,) DATE SURVEY COMPLETED
		09G223			08/12/2011
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	es, inc	63	EET ADDRESS, CITY, STATE, ZIP CODE 217 16TH STREET, NW /ASHINGTON, DC 20012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
W 000	INITIAL COMMEN	rs	W 000	Received 9/7/	U:
	August 11, 2011 th utilizing the fundam random sample of a population of one	rvey was conducted from rough August 12, 2011, lental survey process. A two clients was selected from female and three males with ellectual and developmental		Health September 2 Licensing Administrators and a Care Facilities Divisions No. 20002 Weshington, D.C. 20002	: : :
W 158	observations at the program, interviews review of clinical ar including incident re	survey were based on group home and one clients and staff and the dadministrative records, eports.	W 156	In the future, the facility will report the re all investigations to the administrator or	suits of
	to the administrator or to other officials	vestigations must be reported or designated representative in accordance with State law days of the incident.		designated representative within the req five working days of the incidents.	9/6/11
	Based on interview failed to report the administrator or defive working days of	s not met as evidenced by: y and record review, the facility results of investigations to the signated representative within f the incidents, for two of the j in the facility. (Clients #1 and			
•	The findings includ	e: ·	:		. ,
	reports on August 1	ly's incident and investigative 11, 2011, beginning at 9:16 following incidents and s:	; † ; ;		
ABOD AFTER	V NIDERTODIS OD SBOUL	DER/SUPPLIER REPRESENTATIVES SIGN	ATURE	1) TITLE	; (/@) DA7€
ABUN ABUR	TAMAN PROMI		ANY /	Dine Tan)	9/7/11

following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

09-07-2011 PRINTED: 08/29/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	42 FOR MEDICARI	E & MEDICAID SERVICES			OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPLE CONSTRUCTION	(X3) DATE S	
,		`	A. BU	LDING	-	•
		09G223	B. WI	lG	08/1	2/2011
	ROVIDER OR SUPPLIER NITY MULTI SERVIC	ES, INC		STREET ADDRESS, CITY, STATE, ZII 6217 16TH STREET, NW WASHINGTON, DC 20012		
(XA) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(KS) COMPLETION DATE
W 158	1. On August 3, 2/discovered a bruis arm. The staff not disabilities profess client was question occurred" at his dainformation was obtilent was assessed nurse. Review of the complete dated August 3, 20/divestigation was of the investigative rethe administrator his	D11, at 6:00 a.m., staff e on Client #3's upper right ified the qualified intellectual ional (QIDP) at 7:00 a.m. The sed and he indicated that "it y program. No further stained from the client. The d by the licensed practical esponding investigative report in 1, revealed that the completed. Further review of port revealed no evidence that ad signed the results of the	W	The QIDP will submit all invitor serious reportable incide Administrator for review and 21 days.	ents to the	9/6/11
	Management Coor 2011, at 11:20 a.m regarding the facili- system. The IMC i reportable incident Administrator's sig 2. On May 26, 201 made an allegation incident report, the her bed to participa client swore at the	onducted with the Incident dinator (IMC) on August 11, ., to ascertain Information by's Incident management indicated that the serious is do not require the nature. 1, at 7:50 a.m., Client #1 of abuse. According to the client was being assisted from the in morning hygiene. The staff and tried to punch the				
	her hand, making of The client then ma hit her. On August 11, 201 investigative report	he staff blocked the punch with contact with the client's hand. de an allegation that the staff 1, at 10:00 a.m., review of the revealed that the investigation June 21, 2011. (twenty six				

PRINTED: 08/29/2011 FORM APPROVED OMB NO, 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(XX) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE 61 COMPLE	
		09G223	B. WING	<u> </u>	08/1	2/2011
	ROVIDER OR SUPPLIER NITY MULTI SERVIC			REET ADDRESS, CITY, STATE, ZIP CO 6217 16TH STREET, NW WASHINGTON, DC 20012	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHQULD BE	GOMPLETION DATE
W 156	Continued From p	<u> </u>	W 156	3.		
	coordinator (IMC) a.m., revealed tha reportable inciden abuse) can be con At the time of the provide evidence	incident management on August 11, 2011, at 11:20 at investigations for serious ats (incidents of allegations of empleted within twenty one days. survey, the facility falled to the administrator was notified of investigative report.	W 158			
	RETARDATION F Each client's activ integrated, coordinated				٠	
	Based on observer review, the facility Disabilities Profest that the active tree coordinated, and a	is not met as evidenced by: ation, interview, and record 's Qualified Intellectual asional (QIDP) falled to ensure atment program was integrated, monitored, for two of two clients mple. (Clients #1 and #2)				, .
	The findings inclu	de:		:		
	failed to ensure C active treatment in	W249. The facility's QIDP lient #2 received continuous or accordance with the learn (IDT) recommendations.		Client #2 will receive continu treatment. The complete document placed in the training book.		9/20/11
	failed to ensure th	W212. The facility's QIDP at Client #1 who received lications had a psychiatric		2. Psychiatric assessment for C completed.	Client #1 was	9/2/11
		1				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE 5 COMPLE	
		09 G223	B. WIN	IG		08/1	2/2011
	OVIDER OR SUPPLIER TY MULTI SERVICE	s, INC		67	ÇET ADDRESS, CITY, STATE, ZIP CODE 217 16TH STREET, NW /ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 159 (Continued From pa	ge 3	W ²	! ! !	•		•
1 	failed to ensure tha program plans (IPP pnce Client #1 succ	/255. The facility's QIDP t each clients' individual b) were reviewed and revised easfully completed an			3. IPP for Client #1 has been reviewe revised. New goal has been impleme		9/12/11
	objective identified 483.440(c)(3)(i) IND	IN THE IPP. DIVIDUAL PROGRAM PLAN	w:	212			
1	The comprehensive dentify the present and where possible	e functional assessment must ing problems and disabilities , their causes.	,		In the future, the primary care nurse ensure annual psychiatric assessme completed on time. The psychiatric assessment for Client #1 was compl	ont la	9/2/11
. ,	Based on observate review, the facility for the received psych	s not met as evidenced by: iion, staff interview and record alled to ensure that each client iotropic medications had a nent, for one of the two clients ant #1)			·		
•	The finding include:	s:	-	į	•		ļ
	administration on A revealed Client #1 redisperidone F/C. In practical nurse (LPI administration, revewere prescribed for Review of the client dated August 2011, a.m., revealed that were incorporated in (BSP) dated March	evening medication ugust 11, 2011, at 8:01 a.m., received Fluoxetine HCi. and nterview with the licensed N), after the medication saled that the medications behavior management. I's physicians orders (POS) on August 11, 2011, at 11:50 the psychotropic medication n a Behavior Support Plan 20, 2011, to address ad with physical and verbal n-compliance.					
	Review of Client #1	's medical evaluation dated		! !			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	1'''	IULTIPL LDING	E CONSTRUCTION	(XS) DATE 8 COMPL	
•		09G223	B, WII	VG		08/	2/2011
	ROVIDER OR SUPPLIER NITY MULTI SERVICI	ES, INC		621	et adoress, city, state, zip code 7 16th street, NW Ashington, DC 20012	,	•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROBS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 212	revealed that the prescribed to address	age 4 ay 26, 2010, at 3:00 p.m., sychotropic medications were ass the client's behaviors liagnosis of schizophrenia.	W	212			, ,
W 249	August 11, 2011, a revealed that Clien psychiatrist monthly record, she confirm a psychiatric assessing the confirm and psychiatric assessing the confirm and psychiatric assessing the confirm and confirmation and confirmati	egistered nurse (RN) on t approximately 3:00 p.m., t #1 is assessed by the y. After the RN reviewed the ned that the client did not have sment.	w:	249			
	formulated a client each client must re treatment program interventions and s and frequency to s	erdisciplinary team has sindividual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program	· .		·		
	Based on observa review, the facility : Behavior Support F	is not met as evidenced by: tion, interview, and record staff falled to ensure a client's Plan (BSP) was implemented e of two clients included in the	,				
	The finding include	s:		İ	•		
	staff remained in cl	ensure that Client #2's 1:1 ose proximity of the client as P, as evidenced below:		!			
	On August 11, 201	1, at 4:21 p.m., Client #2 was					: :

PRINTED: 08/29/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULT A. BUILDIN	IPLE CONSTRUCTION RG	(X3) DATE S COMPLI	
<u> </u>		09G223	B. WING_		08/1	2/2011
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	is, inc	. 1	REET ADDRESS, CITY, STATE, ZIP CODE 1217 16TH STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Continued From particular continued From particular continued From particular continued in the assigned 1:1 staff for Client and continued continu	the dining table tracing the ich last name. The evening it left the dining table and was dinner in the kitchen. There ich separating the kitchen and it which made it difficult for aff to visually see Client #2. approximately one (1) minute Client #2 was left again at the and tracing his name while his back to the kitchen to continue the 1:1 staff returned back to proximately 2 minutes later. If staff on August 12, 2011, at a.m., revealed that Client #2 y 24 hours a day to manage haviors and safety. (i.e. ing of others and elopement). Ith Client #2's 1:1 staff she did not remain in close int at all times as observed on impulse control disorder. If see BSP dated July 6, 2011, on 6 p.m., confirmed the 1:1 in aforementioned	W 249	DEFICIENCY)	been the BSP. salning in	9/23/11
	#2's BSP revealed t within arms reach a community, and day	ors. Further review of Client that the 1:1 staff must remain that the 1:1 staff must remain that the 1:1 staff must remain that the 1:1 staffing was in place for elative to sexually			·	

		AND HUMAN SERVICES & MEDICAID SERVICES			· 	FORM): 08/29/2011 1 APPROVED), 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		IPLE CONSTRUCTION	(X3) DATE 8 COMPL	SURVEY
		09G223	8. W	NG_		OR/	12/2011
	PROVIDER OR SUPPLIER NITY MULTI SERVICE			1	REET ADDRESS, CITY, STATE, ZIP CODE 1217 16TH STREET, NW WASHINGTON, DC 20012	<u> </u>	
(XA) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	COMPLETION DATE
W 249	Continued From page	ge 6	W:	249	1	_	
W 255	propositioning other 483.440(f)(1)(i) PRO CHANGE	8. : DGRAM MONITORING &		255		•	· :
	least by the qualified professional and revolution timited to site	rised as necessary, including, uations in which the client has sted an objective or objectives					
	Based on observativerification, the facilities profession that each clients indiwas reviewed and resuccessfully comple	not met as evidenced by: on, staff interview, and record ity's qualified intellectual nal (QIDP) failed to ensure lvidual program plan (IPP) svised once the client had ted an objective identified in lie two clients in the sample.	٠.		The IPP for Client #1 is being reviewerevised. In the future, the QIDP will map progress and revise the IPP goal as no	onitor the	9/23/11
	The finding includes:	. '		!		. 1	
	at 5:28 p.m., Client # her plate from the di kitchen sink, after ve Interview with the clie that she assists with later, in a face to face support staff, it was o	rations on August 11, 2011, it was observed removing ning table and taking it to the rbal prompting from staff. ant at 5:35 p.m., indicated household chores. Minutes a interview with the direct confirmed that the client will old chores, when she is in a		; 		; ; ;	
	August 12, 2011, at a	s IPP dated May 6, 2011, on improximately 11:00 a.m., bjective which stated, "After i		1		:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 0PG223 08/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW COMMUNITY MULTI SERVICES, INC Washington, DC 20012 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 1D (XS) PLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRĖFIX PREFIX TAG DATE TAG DEFICIENCY) W 255 Continued From page 7 W 255 Program objective for Client #1 is to dinner and dessert, [the client] will be encouraged encourage him to follow simple auditory to follow simple auditory commands such as take commands such as take your plate to the your plate to the kitchen on 3/5 trials." Review of kitchen on 3/5 trials will be removed from the the data sheets from July 2010 through August IPP. A new goal/ objective will be developed 2011, revealed that the client met the established and implemented. QIDP will monitor objectives criteria. monthly for progress and will revise criteria W 325 482.460(a)(3)(iii) PHYSICIAN SERVICES W 325 9/16/11 when met. The facility must provide or obtain annual physical; examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP). for one of two clients included in the sample. (Client #2) The finding includes: The facility's nursing service failed to ensure Client #2's routine laboratory studies (Depakote) were obtained as recommended by the primary care physician, as evidenced below: On August 11, 2011, at 7:35 a.m., observation of the morning medication administration pass revealed that Client #2 was administered Depakote 500 mg by mouth. Review of Client #2's medical records on August 12, 2011, beginning 9:20 p.m., revealed a physician's order (PO's) dated August 2010.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING B. WING 09G223 08/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6217 16TH STREET, NW** COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 325 Continued From page 8 W 325 The nursing staff will ensure the Client #2's According to the PO's, Client #2's depakote levels depakote levels are monitored every three were to be monitored every three months. months with laboratory studies as prescribed Subsequent review of his medical records by the primary care physician. 9/8/11 revealed there were no laboratory studies done six months prior to the March 15, 2011, for depakote. The primary nurse will review the physicians's order and schedule required Interview with the facility's registered nurse (RN) laboratory test. The primary care nurse will 9/12/11 and further record review on August 12, 2011, at receive additional training by the DON. 10:25 a.m., confirmed that laboratory studies for depakate were not completed every three months. as prescribed. W 331 483.460(c) NURSING SERVICES W 331 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, Interview, and record review, the facility failed to ensure nursing services were provided in accordance with the needs for, three of of four clients residing in the facility. (Clients #1, #2, and #3) The findings include: 1. Cross refer to W325. The facility's nursing 1. Cross reference W325 9/8/11 staff failed to ensure routine laboratory testing as determined necessary by the physician for Client #2. 2. Cross refer to W389. The facility nursing staff 2. Cross reference W389 9/5/11 failed to ensure biological included appropriate accessory and instructions on pharmacy labels for Clients #1 and #3. W 371 483.460(k)(4) DRUG ADMINISTRATION W 371

		AND HUMAN SERVICES	•		·	FORM	D: 08/29/2011 MAPPROVED D: 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. Bu		LTIPLE CONSTRUCTION DING	(X3) DATE COMPI	BURVEY
		09G223	B. W	ING		08/	12/2011
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	s, INC		8	STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION 8H CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
W 371	that clients are taug medications if the indetermines that self is an appropriate obdoes not specify other than the self is an appropriate obdoes not specify other than the self is an appropriate obdoes not specify other than the self is as recommended by for one of the two client as recommended by for one of the two client is medication of the naugust 11, 2011, at licensed practical nutries medications and driefly went to the kitch and documented the medication administration and the LPN emparticipate in the medication completed, review of data collection sheet	g administration must assure ht to administration must assure ht to administer their own sterdisciplinary team sadministration of medications elective, and if the physician serwise. In not met as evidenced by: sons, interviews and the se facility failed to implement to ensure that each client f-medication training program of the interdisciplinary team, sents in the sample (Client election administration on 8:01 a.m., revealed the street (LPN) punched Client of a medication cup. The envel swallowing the sadministration in the client's ration record (MAR). At no courage the client to dication administration adminis	W	37	The nursing staff will be trained on hencourage the individuals to particip Medication Administration Program.	ate in the	9/7/11

		AND HUMAN SERVICES & MEDICAID SERVICES			•	FORM): 08/29/2011 1 APPROVED), 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		LTIPLE CONSTRUCTION DING	(X3) DATE S	BURVEY
		09G223	B. WI	NG)	08/	12/2011
	PROVIDER OR SUPPLIER	•		a	TREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW		
COMMU	NITY MULTI SERVICE	s, inc			WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	÷ΙΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 8HO GROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 371	Continued From page	ge 10	w	37	1 Self Medication Administration Train	lna le	;]
	- Wash her hands;	- · · · · · · · · · · · · · · · · · · ·			provided in the evening by the pm n	urse. All	
	- Obtain and pour w	ater;			clients will be given the opportunity to participate in self-medication admini- training. The nursing staff will docum	stration	· ·
	- Identify her [the cli	ent] on blister pack or bottle;			progress on a daily basis.	10116	9/12/11
	- Identify Tegretol m	edication;					
	- State purpose of T	egretol; and			!		i
	- Punch out medical	lions from blister pack.			j	•	
·	revealed a self med June 23, 2011. Acc Client #1 was recom program. Minutes in Individual program revealed a program	ugust 12, 2011, at 10:00 a.m., ication assessment dated ording to the assessment, mended for a self medication ater, review of Client #1's plan (IPP) dated May 6, 2011 objective which stated, "[the in self medication program lence.					
W 381	There was no evider implemented Client program as recomm 483.460(i)(1) DRUG RECORDKEEPING	#1's self-medication training :	ws	38 [,]	1		1
	The facility must sto conditions of security	re drugs under proper ,					
·	Based on observativerification, the facilities ensure that controlle	not met as evidenced by: on, staff interview and record ty failed to implement and d substances were stored for one of the four clients v. (Client #4)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER. AND PLAN OF CORRECTION A BUILDING B. WING 08/12/2011 09G223 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6217 10TH STREET, NW** COMMUNITY MULTI SERVICES, INC **WASHINGTON, DC 20012** (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDI-NTIFYING INFORMATION) PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 381 W 381 Continued From page 11 The facility will purchase a box with a lock for all control aubstances. All control medications The finding includes: will be placed under double locks. 9/6/11 On August 11, 2011, at 7:35 a.m., the licensed practical nurse (LPN) was observed unlocking a file cabinet that contained the clients medications. At 7:54 a.m., he was observed retrieving a box from the cabinet containing the Clonazepam. The box did not have a lock on it. Seconds later, he was observed administering the Clonazepam to Client #4. Interview with the LPN, after the medication administration on August 11, 2011, at approximaterly 8:05 a.m., revealed that the nurse's were having difficulty with the lock on the medication box and therefore removed the lock. On August 12, 2011, at 2;36 p.m., the Clonazepam was in a box inside the medication cabinet under one lock. At 2:36 p.m., the registered nurse (RN) confirmed that the medication was stored using one lock. The RN indicated that the agency's policy revealed that controlled substances (Clonazepam) should be stored utilizing double locks. Review of the agency policy on August 12, 2011, at 2:45 p.m., confirmed the RN's statement. W 389 W 389 483.460(m)(1)(ii) DRUG LABELING Labeling for drugs and biologicals must include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

This STANDARD is not met as evidenced by:

PRINTED: 08/29/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G223 08/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6217 16TH STREET, NW COMMUNITY MULTI SERVICES, INC** WASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ίD (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) W 389 Continued From page 12 W 389 In the future, the primary nurse will check all Based on observation, staff Interview and record medications for appropriate medication review, the facility failed to ensure all drugs and instruction labels. Any medication with no biologicals included appropriate accessory and appropriate label will be removed from the instructions on pharmacy labels, for two of the medication box. This will be done on a weakly four clients residing in the facility. (Clients #1 and 9 /15/11 #3) The findings include: 1. During the medication administration observation on August 11, 2011, at 8:01 a.m., the licensed practical nurse (LPN) administered one drop of Dorzolamide Hydrochloride eye drops to Client #1's eyes. Review of the medication bottle revealed the client's name and the name of the medication was printed on the bottle. However, the bottle did not indicate any instructions for administration (number of drops or how often the medication should be administered). After the medication administration, an inquiry was made to the LPN to ascertain information regarding instructions on Client #1's medication (Dorzolamide) pharmacy label. The LPN revealed that there was no instructions on the eve drop bottle. She further indicated that the instructions were on Client #1's medication administration record. 2. Similarity, Client #3 did not have instructions on his pharmacy label as evidenced below: During the medication administration observation on August 11, 2011, at 7:47 a.m., it was revealed that the LPN administered Dorzolamide Hydrochioride eye drops to Client #3's eyes. Review of the medication bottle revealed the

client's name and name of the medication was

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09-07-2011

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE 8 COMPLE	
	· .	09G223	B. Wil	IG _		08/1	2/2011
	PROVIDER OR SUPPLIER UNITY MULTI SERVICE	· · · · · · · · · · · · · · · · · · ·		•	REET ADDRESS, CITY, STATE, ZIP CODE 217 16TH STREET, NW VASHINGTON, DC 20012		
(X4) II PREFI TAG	({EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
W 38	indicate any instruc	a. However, the bottle did not tions for administration r how often the medication	w:	389 - 			
W 39	was made to the LF regarding instruction (Dorzolamide) phane revealed that there drop bottle. She full instructions were or administration records.	· 	W 3			-	
	The facility must rer	nove from use drug n, illegible, or missing labels.			Cross reference W389		9/15/11
	Based on observati facility failed to rema	s not met as evidenced by: ion and staff interview, the ove medications from its use el, for one of the two clients in #1)		į į			
	The finding includes	:		}			
	environmental inspet Lotion was observed hygiene kit. Further bottle had a wom ph	, at 2:05 p.m., during the action, a bottle of Beta-Val d in Client #2's personal observation revealed that the narmacy label. According to oserved information was the	,				
	management coordi	nental inspection, the incident nator confirmed that the office had a worn label.		i		:	

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	WI OIL WEDIONIKE	G MEDICAID SELAICES				CINID ITO.	1 000-0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		09G223	B. WI	NG_		08/1	2/2011
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	:8, INC		6	REET ADDRESS, CITY, STATE, ZIP CODE 217 16TH STREET, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 441	483.470(i)(1) EVAC The facility must ho varied conditions.	UATION DRILLS	W 4	441	QIDP will ensure that all exits under fire drills are to be conducted are util including use of the basement door, will be reviewed quarterly.	ized	9/8/11
	Based on the inter- records, the facility under varied conditi	s not met as evidenced by: view and review of the fire drill failed to conduct fire drills lons, for four of four clients by. (Clients #1, #2, #3, and #4)					
	The finding includes	3:		ļ		•	
•	August 11, 2011, at facility had at least t door, back door, sid and the basement of fire drill records on a 11;43 a.m., revealed were conducted utili door, and side door fire drill records revealt was not used for present. At 12:15 p the basement door past year. There we	ouse Manager (HM) on 11:41 a.m., revealed that the five methods of egress (front le door, side door on 3rd floor, loor). Review of the facility's August 11, 2011, beginning at d that most of the fire drills izing the front door, back exits. Further review of the ealed that the basement door om September 2010 to .m., the HM confirmed that exit was not utilized during the as no evidence on file at the bstantiate that all exits were					
	,			 	·	 	
·		: : 		-			

04:58:26 p.m.

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G223			(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/12/2011		
ME OF PROVIDER OR SUPPLIER		· -		TATE, ZIP CODE			
OMMUNITY MULTI SERVICE	ES, INC		TH STREET, NW IGTON, DC 20012				
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
1000 INITIAL COMME	NTS		000				
11, 2011 through three residents we one female and th	y was conducted from August 12, 2011. A sa as selected from a pop iree male residents wit evelopmental disabilitie	emple of Julation of The various				; ;	
observations, inte	e survey were based or rviews with residents a as well as a review of records, including inc	and staff, ; resident			•	:	
1 180 3508.1 ADMINIST	TRATIVE SUPPORT	1	180			:	
. administrative sup	all provide adequate port to efficiently meet lents as required by the			•			
Based on observa review, the Group intellectual Disabl adequate adminis provided to effecti	ot met as evidenced by ation, interview and rec Home for Persons wit lities (GHPID) failed to trative support had be evely meet the needs, founded in the sample. (Founded)	ord th ensure en or two of			·	:	
The findings inclu	de:		ſ	Cross reference W249		9/23/11	
to ensure 1:1 staf	193. The GHPID's QIE I demonstrated compe sident #2's behavior su	tency in				;	
failed to ensure R active treatment in	W249. The GHPID's (esident #2 received co n accordance with the am (IDT) recommends	ontinuous :				:	
Ith Regulation & Licensing Admi	nistration	Y ,	Lana m	Wriston Tyle		(KB) DATE	
amanul.	DENSUPPLIER REPRESEN	TATIVE'S SKINAT	TYLAIIL	MANAGE	9	17/11	

Health R	tegulation & Licensin	ng Administration						
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPFLIE IDENTIFICATION NUI		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2011		
NAME OF P	ROVIDER OR SUPPLIER	-	STREET ADDI	RESS, CITY,	STATE, ZIP CODE			
			6217 16TH	TH STREET, NW NGTON, DC 20012				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFIGIENCY)	HOULD BE	(X6) COMPLETE DATE	
1 203	descriptions with exemployment and all the employment and all the employment and all the employment are to employees were programmed by this sec #6, #8, #9, #10, #1. The finding include: On August 12, 201 interview with the horeview of the perso GHPID's failed to pracility had discussed descriptions, for elections and all the employments are the employees.	tall discuss the content of the least annually therest and interview, the least and interview, the least and least the least the least the least	nts of job beginning after. he group illities ixteen by to ions as #4, #5, p.m., and e the onployees.	1 203	The contents of the job description of the jo	#10, #11, d and espectively as	9/23/11	
	annually thereafter, certification that a h performed and that would allow him or duties. This Statute is not	EL POLICIES for to employment any shall provide a physicalith inventory has be the employee's heather to perform the recomment as evidenced by and record review, the	d ician 's eeen aith status quired	I 206				
lealth Regula	ation & Licensing Admini	stration		···	JHH811	If continuatio	n sheet 2 of 12	

04:58:57 p.m. 09-07-2011

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Health R	Regulation & Licensin	g Administration					
	PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	2) MULTIPLE CONSTRUCTION BUILDING WING		URVEY ETED 2/2011	
NAME OF D	ROVIDER OR SUPPLIER	- VOULA	STREET ADD	RESS CITY	STATE, ZIP CODE	00/1	2/2011
CONTRACTOR AND 6217			6217 16TH WASHING	STREET,	NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 8HO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(XS) COMPLETE DATE
1 206	Continued From page 2			1 208	Nurse #1's heaith certificate will be	placed on	9/8/11
	Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that one of the eigh nurses (Nurse #1) and one of the nine consultants (Pharmacist) had current health certificates.		eight		file.		
The finding includes: On August 12, 2011, beginning at 11: review of the personnel records reveal GHPID failed to have evidence of cur certificates for one of the eight nurses the nine consultants. The staff confinence on the pharmacist were we current health certificates in their personnel.		1, beginning at 11:00			The pharmacist's current health certibe placed on file. In the future, the Control of the check personnel records on a month	OIDP WIII	9/15/11
		ve evidence of currer of the eight nurses a s. The staff confirme pharmacist were with	nt health nd one of p ad that nout		order positional records of a money		9/10/11
1227	3510.5(d) STAFF T			1 227			
	limited to, the follow	am shall include, but ving:	not be	,			
	(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;				CPR for employee #5 will be placed personnel record. QIDP will monitor quarterly for current CPR certification	files	B/21/11
·	Based on interview home for persons w (GHPID) failed to he training in cardiopul	met as evidenced by and record review, it rith intellectual disabl ave on file for review Imonary resuscitation mployees. (Employe	he group ilities , current , (CPR),			•	
	The finding include:	· 3:	:				
	The GHPID failed to ensure a current CPR certification was on file for Employee #5. This was confirmed by the house manager (HM) at approximately 1:00 p.m., who looked through		, This IM) at				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G223		B. WING_		08/1:	2/2011
NAME OF P	ROMDER OR SUPPLIER	0.02.00	STREET ADD	RESS, CITY,	STATE, ZIP CODE		
COMMUN	IITY MULTI SERVICE	5, INC	6217 16TH WASHING	STREET, TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL `	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(XS) COMPLETE DATE
1 227	Continued From pa	ge 3		1 227			•
	Employee #5's pers	ional files.					,
. 1399	3520.2(i) PROFESS PROVISIONS	SION SERVICES: GI	ENERAL	1 399			:
	professional staff to necessary professionaccordance with the individual habilitationecessary by the in professional service limited to, those ser trained, qualified, as	have available quality or carry out and monitoral interventions, in a goals and objective on plan, as determine terdisciplinary team, as may include, but no vices provided by include as required law in the following of services;	s of every d to be The ot be	, .			
	(i) Speech and lan	iguage therapy; and.			A current professional licens from the Speech Pathologist		9/16/11
	Based on interview falled to ensure that credentials was ma providing profession	met as evidenced by and record review, that a copy of profession intained for each ind nal services at the Grof Columbia law, in to or area:	he GHPID nal ividual HPID, as :		inom the Special Faulungist	•	9/10/11
	(i) Speech and Lang	guage Therapy.					
•	The finding is:		į			•	!
	2011, beginning at current professiona the Speech Langua approximately 12:30 intellectual disabilitithe license/professi	D p.m., the GHPID's es professional confi onal credentialing for Therapist was not av	that a illable for qualified rmed that . r the		:		

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Health R	egulation & Licensin	ng Administration					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S COMPL	
		09G223		B. WING_		08/1	<i>2/</i> 2011
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	REBS, CITY,	STATE, ZIP CODE		•
COMMU	NITY MULTI SERVICE	ES, INC		STREET, I TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	. (X5) COMPLETE DATE
l 399	Continued From pa	nge 4	į	1 399			1
	professional licensice evidence that the companies was licens of Columbia, in accompanies and columbia and	of the District of Colu- LICENSING, DR CERTIFICATION SIONALS se, registration, or ce di pursuant to this cha emedicine, acupuncta ered nursing, practica giene, distetics, marr ssage therapy, naturo nursing home admin oy, optometry, pharm y, physical therapy, po- work, professional co- language pathology, tvanced practice add- actice as an anesthe n assistant, physical transpraphic technologic by assistant, or surgice	vealed no nguage District Imbia OF rtification pter is ure, Il nursing, lage and opathic distration, accutical odiatry, unseling, liction stologist herapy st, cal				
	provided in this cha	` nation was presented	:	•			
i 401	3520.3 PROFESSI PROVISIONS	ON SERVICES: GEN	IERAL	I 401		•	!
•	and evaluation, incl	es shall include both luding identification o ils and needs, treatm	f				

Health R	legulation & Licensin	g Administration	·····				
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G223			(X2) MULT A. BUILDIN B. WING_	IPLE CONSTRUCTION	(X3) DATE 8 COMPLE	TED
						U6/1.	2/2011
NAME OF P	ROVIDER OR SUPPLIER	'			STATE, ZIP CODE		
COMMU	NITY MULTI SERVICE	S, INC		TON, DC 2		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	full	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
I 401	Continued From pa	ge 5	;	1 401			;
	services, and services designed to prevent deterioration or further loss of function by the resident.						:
	Based on observati review, the Group i- intellectual Disabilit professional service and evaluation, incl developmental leve services, and service deterioration or furti- resident for two of the	s Statute is not met as evidenced by: sed on observation, interview and record lew, the Group Home for Persons with ellectual Disabilities (GHPID) failed to ensure fessional services that included both diagnosis if evaluation, including identification of relopmental levels and needs, treatment vices, and services designed to prevent erioration or further loss of function by the ident for two of two residents included in the upple. (Residents #1 and #2)					
	The findings include	9 :	. !	ı	Cross reference W325		9/6/11
	Resident #2's routin (Depakote) were of	rrsing service failed to ne laboratory studies otained as recommen sysician, as evidenced	ided by				
	the morning medica	1, at 7:35 a.m., obser ation administration p lent #2 was administe by mouth.	225				· .
	August 12, 2011, be physician's order (P According to the PC levels were to be m Subsequent review revealed there were	#2's medical records eginning 9:20 p.m., re PO's) dated August 20 D's, Resident #2's deponitored every three of his medical records no laboratory studie the March 15, 2011, 1	evealed a 010. bakote months. is				
		HPID's registered nu eview on August 12,					

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09-07-2011

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			(X2) MUL' A. BUILDI B. WING		(X3) DATE SURVEY COMPLETED - 08/12/2011		
		09G223	CTREET ARC	TREET ADDRESS, CITY, STATE, ZIP CODE				
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	ES, INC	6217 16TH WASHING	STREET,	NW			
(X4) ID PREFIX TAG	((EACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC' REGULATORY OR LSC (DENTIFYING INFORMATION) TAG : CROSS-REFERENCED TO			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
i 401	401 Continued From page 6		1	l 401				
	10:25 a.m., confirmed that laboratory studies for depakote were not completed every three mont as prescribed.							
	The facility failed to ensure that each residents who received psychotropic medications had a psychiatric assessment, for Resident #1				Cross reference W212		9/2/11	
	administration on A revealed Resident; and Risperidone F/practical nurse (LP administration, revewere prescribed for Review of the resid dated August 2011 a.m., revealed that were incorporated (BSP) dated March	evening medication August 11, 2011, at 8: #1 received Fluoxetir C. Interview with the N), after the medicate alied that the medicate behavior management's physicians order, on August 11, 2011 the psychotropic medical and the physical and the compliance.	ne HCL licensed on ations ent. ers (POS) , at 11:50 dications t Plan				t	
	July 7, 2009, on Ma revealed that the pr prescribed to addre associated with a d	t #1's medical evalua ay 26, 2011, at 3:00 p sychotropic medication ass the resident's beholiagnosis of schizopho	o.m., ons were naviors renia.		Cross reference W212	·	9/2/11	
	August 11, 2010, a revealed that Residestriation psychiatrist monthly	n the registered nurse (RN) on 010, at approximately 3:00 p.m., Resident #1 is assessed by the nonthly. After the RN reviewed the onfirmed that the resident did not liatric assessment.					J:	
) 422	3521.3 HABILITAT	ION AND TRAINING	; ;	1 422			‡	
	and assistance to r	l provide habilitation, esidents in accordan istration				<u></u>	!	

meaill) h	rednisnou & riceusiu	n Valillingnanoli		1		····	
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G223			(X2) MULT A. BUILDIN B. WING		COMPLETED 08/12/2011	
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS. CITY.	STATE, ZIP CODE		
	NITY MULTI SERVICE	is, inc	6217 18TH WASHING	STREET,	W		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SKOULD BE	(X5) COMPLETE DATE
1 422	Continued From pa	ige 7		1 422	1		
	•	_	.				i
	tue tealoaut 'a tuot	vidual Habilitation Pla	an. '				•
	Based on observati review, the group h intellectual disabiliti that residents' train implemented in acc	met as évidenced by ion, interview and recome for persons with les (GHPiD) failed to ing objectives were cordance with their in for one of two residence. (Resident #2)	cord ; the same is a second consumer in the same in				•
	The finding include	s:			Cross reference W249		9/23/11
	1:1 staff remained	o ensure that Reside in close proximity of t ed in his BSP, as evi	the				
·	was observed sitting the letters of his first evening 1:1 staff for table and was observed. The staff reminute later. At 4:2 again at the dining name while his 1:1		tracing te dining tracing				• • • • • • • • • • • • • • • • • • • •
	approximately 9:20 #2 received 1:1 sta manage his malada (i.e. inappropriate t elopement). Furth 1:1 staff acknowled	<u> </u>	Resident to safety. d sident #2's remain in				

09-07-2011

Health R	egulation & Licensin	g Administration					
	r of deficiencies of correction	(X1) PROVIDENSUPPLIE IDENTIFICATION NUI		(X2) MULT A BUILDIN B. WING	-	(X3) DATE 5 COMPL	ETEO
	•	09G223				08/1	2/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE		•
COMMUN	NITY MULTI SERVICE	s, inc	6217 16TH WASHING				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID' PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
l 422	Continued From pa	ge 8		422			
	review of Resident: the resident had dis	1, beginning at 9:20 a #2's medical records agnoses of pedophilia rchosis, and impulse	revealed i	·	•		
	on the same day at staff's interview of the maladaptive behaving Resident #2's BSP must remain within home, community, also added that Resident #2's also ad	iors. Further review of revealed that the 1:1 arms reach at all time and day program). To staffin cautions relative to se	the 1:1 staff es (i.e., he BSP g was in				
1 424	3521.5(a) HABILITA	ATION AND TRAININ	IG	1424			
		make modifications at least every six (6	,-				
		y completed an object In the Individual Hab					
	Based on staff inter Qualified Mental Re (QMRP) failed to re Program Plan (IPP) successfully complete	met as evidenced by view and record review and record review and revise the life once the residents heted an objective ider the two residents in the two res	ew, the paid in the state of th		Cross reference W159		9/12/11
	The finding includes	5 :			•		:
	During dinner obser	vations on August 11	, 2011,				

i

ng Administration		y			
IDENTIFICATION NU				(X3) DATE SURVEY COMPLETED 08/12/2011	
	STREET ADD	RESS. CITY.	STATE ZIP CODE	00/1/	22011
ES, INC	6217 16TH	STREET,	NW ,		
SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOU	ULD BE	(X5) COMPLETE DATE
dent #1 was observed dining table and takin verbal prompting from resident at 5:35 p.m., ith household chores. ace interview with the med that the resident ehold chores, when some the detail and the state of the kitchen or the data sheets from . 11, revealed that the state of the kitchen or the data sheets from . 11, revealed that the state of the kitchen or the data sheets from . 11, revealed that the state of the kitchen or the data sheets from . 11, revealed that the state of the kitchen or the data sheets from . 11, revealed that the state of the kitchen or the data sheets from . 11, revealed that the state of the kitchen or the data sheets from . 11, revealed that the state of the kitchen or the data sheets from .	g it to the staff. indicated Minutes direct will he is in a 16, 2011, 1:00 a.m., ed, "After mmands in 3/5 July 2010		Cross reference W255		9/23/11
d training of residents de, when appropriate ollowing areas: sluding skills related to distration of medication of prosthetic and orthose health care, and safet met as evidenced by tions, interviews and the property of the	by the but not on nutrition, in, first otic ety); the review of the resident program,	I 436	Cross reference W371		9/7/11
	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 09G223 ES, INC ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY LSC IDENTIFYING INFORMATION AND TRAINING THE PROPERTY OF THE PROVIDER OF	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 09G223 STREET ADD 6217 16TH WASHING ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) age 9 dent #1 was observed removing dining table and taking it to the verbal prompting from staff. resident at 5:35 p.m., indicated ith household chores. Minutes ace interview with the direct med that the resident will ehold chores, when she is in a int #1's IPP dated May 6, 2011, 1, at approximately 11:00 a.m., in objective which stated, "After it, [the resident] will be ow simple auditory commands plate to the kitchen on 3/5 the data sheets from July 2010 i11, revealed that the resident id criteria. ATION AND TRAINING d training of residents by the ide, when appropriate, but not	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G223 STREET ADDRESS, CITY, 6217 16TH STREET, WASHINGTON, DC 2 ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) Age 9 Ident #1 was observed removing dining table and taking it to the verbal prompting from staff. resident at 5:35 p.m., indicated ith household chores. Minutes ace interview with the direct med that the resident will sehold chores, when she is in a Int #1's IPP dated May 6, 2011, 1, at approximately 11:00 a.m., m objective which stated, "Affer t, [the resident] will be ow simple auditory commands plate to the kitchen on 3/5 the data sheets from July 2010 Int, revealed that the resident d criteria. ATION AND TRAINING I 436 ATION AND TRAINING I 436 I 436 I 436 I 436 I 437 I 438 I 436 I 436 I 436 I 436 I 436 I 436 I 437 I 438 I 439 I 439 I 441 I 441 I 441 I 442 I 442 I 442 I 442 I 442 I 442 I 444 I 444 I 445 I 445 I 445 I 446 I 446 I 447 I 447 I 448 I 449 I 441 (X1) PROVIDER/SUPPLIER/GIA IDENTIFICATION NUMBER: 09G223 STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW WASHINGTON, DC 20012 ATEMENT OF DEFICIENCIES ID PREFIX ASHINGTON, DC 20012 ATEMENT OF DEFICIENCIES ID PREFIX TAG CROSS-REFERENCED TO THE APPR CROSS-REFERENCED TO THE APPR DEFICIENCY) Bage 9 Ident #1 was observed removing dining table and taking it to the verbal prompting from staff. resident at 5:35 p.m., inclicated th household chores. Minutes are interview with the direct remed that the resident will whold chores, when she is in a Int #1's IPP dated May 8, 2011, 1, at approximately 11:00 a.m., In objective which stated, "After t, (the resident) will be ow simple auditory commands plate to the kitchen on 3/5 the date sheets from July 2010 111, revealed that the resident d criteria. ATION AND TRAINING Identify the commands of the commands of the commands interview and the review pup Home for Mentally (GHMRP) failed to implement into ensure that each resident if medication training program,	(X1) PROVIDER/SUPPLIER/CIA DESCRIPTION NUMBER: 090223 STREET ADDRESS, CITY, STATE, ZIP CODE 6217 16TH STREET, NW WASHINGTON, DC 20012 ATEMENT OF DEFICIENCIES Y MUST BE PRICEDED BY FULL SEC DENT/FIVING INFORMATION) AGE OF DEFICIENCIES 217 16TH STREET, NW WASHINGTON, DC 20012 ATEMENT OF DEFICIENCIES Y MUST BE PRICEDED BY FULL SEC DENT/FIVING INFORMATION) AGE OF DEFICIENCY ATEMENT OF DEFICIENCIES 218 1 1 2 2 1	

Health R	egulation & Licensin	g Administration		т			
	r of deficiencies of correction	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/12/2011	
		09G223	PTREET ADDS	see cmy	STATE, ZIP CODE	1 00/1/	92011
	ROVIDER OR SUPPLIER NITY MULTI SERVICE	s, INC	6217 16TH WASHINGT	STREET,	WW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY BC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
1 436	Continued From pa	_		1 436	Cross reference W371	Х.	9/12/11
	Observation of the August 11, 2011, at licensed practical numbers of the March 11 medications and drug the March 12 medications and drug the March 12 medications and documented the resident's medication (MAR). At no time resident to participal administration procession of the medication completed, review of revealed a data collaboration. The March 12 medication completed, review of revealed a data collaboration.	medication administrated is 8:01 a.m., revealed urse (LPN) punched to a medication cup. Observed swallowing the glass of wachen sink, washed him administration recorded the LPN encouragete in the medication	the Resident The the ater. The s hands e ord ge the s was s labeled i a				
	- Wash her hands;	•	• •			· :	
	- Obtain and pour v	vater;	į				
	- identify her [the rebottle;	sident) on blister pac	k or				
	- Identify Tegretol n	nedication;	;				
	- State purpose of T	Fegretol; and					
	- Punch out medica	itions from blister pac	sk.				
	revealed a self med June 23, 2011. Act Resident #1 was re medication program	august 12, 2011, at 10 dication assessment of cording to the assess commended for a seen. Minutes later, revidual program plan (Il	dated ment, If ew of			-	

Health R	egulation & Licensin	o Administration					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 09G223	R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 0B/12/2011	
NAME OF B	ROVIDER OR SUPPLIER	, 000220	STREET ADD	DRESS, CITY,	STATE, ZIF CODE		
	NOTICE SERVICE	ES, INC	6217 16TH	STREET, TON, DC 2	WW .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
1 436	Continued From pa	nge 11		I 436		•	
	stated, "[the resider	ied a program objecti nt] will participate in s n with 100% indepen	elf '			; ;	
	implemented Resid	ence that the facility lent #1's self-medical s recommended by th					
l 484	3522.11 MEDICAT	ions		I 484	Cross reference W389		9/15/11
	medication that is d	l promptly destroy pro discontinued by the pl expiration date, or ha dissing label.	hysician	•		:	
	Based on observati review, the Group I Intellectually Disabl remove medication	met as evidenced by lon, staff interview an Home for Persons wil littles (GHPID) nurse is with wom labels fro esidents in the sampl	d record th falled to om use,			; ,	
•	The findings include	e:				İ	
	environmental insp Lotion was observe hygiene kit. Furthe bottle had a worn p	1, at 2:05 p.m., during ection, a bottle of Ber ed in Resident #2's per er observation reveale charmacy label. Acco observed information e.	ta-Val ersonal ed that the erding to		, , ,		
	management coord	mental inspection, the linator confirmed that otion had a worn lab	I the 1				